DEPARTMENT OF THE NAVY
BOARD FOR CORRECTION OF NAVAL RECORDS
2 NAVY ANNEX
WASHINGTON DC 20370-5100

BJG
Docket No: 5958-98
17 February 2000

[redacted]

Dear Dr. [redacted]

This is in reference to your application dated 12 August 1998 with enclosures, seeking reconsideration of your previous application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

Your previous case, docket number 15834-90, was denied on 11 August 1992. You have now requested reconsideration of your previous case regarding your fitness reports for 25 August 1970 to 30 April 1971 and 1 May 1971 to 2 June 1972. Instead of requesting removal of the reports, as you did previously, you now request that they be annotated to show that certain comments "have been shown to be the product of an unreasonably biased evaluator." You have added a new request to correct the files which resulted in generation of correspondence from the Naval Hospital San Diego, California, similar to the Captain ... , Medical Corps, United States Navy letter to the Director, Little Company of Mary Hospital dated 30 November 1996. Your new request was not considered since the Board for Correction of Naval Records deals only with service records of applicants.

A three-member panel of the Board, sitting in executive session, reconsidered your case on 16 February 2000. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your current application and enclosures, together with all material submitted in support thereof, the Board's file on your prior case, your naval record and applicable statutes, regulations and policies. In addition, the Board considered the advisory opinion furnished by the Division of Cardiothoracic Surgery dated 31 March 1999, a copy of which is attached. They also considered your former counsel's letter dated 4 December 1998 with enclosures and your current counsel's letter dated 16 September 1999 with enclosures.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the comments contained

5958-98

in the advisory opinion. They were unable to find that the fitness report comments of concern to you were the product of a biased evaluator. They do feel the language, in your report for 25 August 1970 to 30 April 1971, "As a foreign medical graduate and originating from a country with considerably different attitudes about the value of life" was offensive and inappropriate. However, they decided not to remove it, because they noted you do not request this; and they found that its inclusion in an otherwise adverse report was not a material error warranting corrective action. In view of the above, the Board again voted to deny relief. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official records. Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER
Executive Director

Enclosure

Copy to:
David P. Sheldon, Esq.

5958-98

Division of Cardiothoracic Surgery

Naval Medical Center San Diego
34800 Bob Wilson Drive San Diego, CA 92134-5000
(619) 532-9140 • (619) 532-8799 FAX

[redacted] USN J.D. Mitchell LCDR MC USNR

31 March 1999

MEMORANDUM

From: Head, Division of Cardiothoracic Surgery
Naval Medical Center
San Diego, CA 92134-5000
To: Chairman, Board for Correction of Naval Records

Subj: COMMENTS AND RECOMMENDATION IN THE CASE OF EX-CDR [redacted] MC, USN [redacted]

Ref: (a) 10 USC 1552
(b) Your letter dated 13 Nov 98

Encl: (1) BCNR File

1. As requested in reference (b), the following paragraphs are my comments and recommendation in the case of ex-[redacted] MC, USNR based on review of enclosure (1).

2. [redacted] was on active duty in the U. S. Navy Medical Corps from December 1968 through June 1972. He initially served as a general surgeon and then entered a thoracic surgery residency at Naval Hospital San Diego. The residency was scheduled to last two years beginning 7 September 1970. He was placed on probation 23 June 1971 and removed from probation 1 September 1971. He was terminated from the residency 15 November 1971 and thereafter functioned as a general surgeon at Naval Hospital San Diego until he left the Navy in June 1972. He later completed a civilian residency in thoracic surgery and became board-certified in the specialty.

3. [redacted] has requested correction of fitness reports for the periods 8/25/70 - 4/30/71 and 5/1/71 - 6/2/72. Specifically, he has requested annotation of part of the comments section in both reports as being the product of an unreasonably biased evaluator. In addition he has requested "Correction of those files which result in generation of official correspondence from the Naval Hospital San Diego similar to that letter attached as Exhibit AA. Such correspondence should give reasonable emphasis to the positive aspects of [redacted] service, and the principal negative information was the product of an unreasonably biased evaluator and not based on fact." Exhibit AA is a letter to a civilian hospital from Naval Hospital San Diego that was written in response to the civilian hospital's inquiry regarding [redacted] performance while he was assigned to Naval Hospital San Diego.

4. The statements for which [redacted] has requested annotation in the first fitness report are "He has required counseling on physician-patient relationships. As a foreign

medical graduate and originating from a country with considerably different attitudes about the value of life, he has had difficulty in appreciating and requiring the tact and rapport which is expected by patients." In the second fitness report, the statements for which he has requested annotation are "During the first few months of this reporting period, when Commander Mir was assigned increasing responsibility as a Thoracic Surgery resident his performance deteriorated. He was placed in a probationary status in June 1971. With close counseling and supervision, his performance temporarily improved, but his performance again declined to the point where it was determined that his residency training in thoracic surgery should be terminated in November 1971."

5. The reporting senior for both of the fitness reports wa[redacted] At the time, [redacted] was a Rear Admiral in the U. S. Navy Medical Corps and was Commanding Officer of Naval Hospital San Diego. However, the evaluator that Dr. [redacted]s identified as being unreasonably biased w[redacted] During the period in question, [redacted] was a Captain in the U. S. Navy Medical Corps and was Chief of the Thoracic Surgery Service at Naval Hospital San Diego[redacted] cited comments and actions by [redacted] at he has claimed are evidence of discrimination against him and that, in his estimation, demonstrate that Dr. Fosburg was an unreasonably biased evaluator. According to [redacted]e pattern of discrimination culminated in his termination from the residency and later hampered his efforts to gain some types of privileges at civilian hospitals.

6. [redacted]as claimed that he was held to a different standard and treated differently than the other residents on the thoracic surgery service from the time he started his residency. He has submitted the case lists of the Thoracic Surgery Service during the time he was a resident with totals showing that he was not given a caseload equivalent to the other resident at his year level in training. [redacted] also submitted a letter he solicited fro[redacted] Jam[redacted] who was an attending surgeon on the teaching staff of the Thoracic Surgery Service during the time o[redacted] residency. In the lett[redacted] stated "From the very onset there appeared to be a personal and cultural conflict between the Chief an[redacted]. [redacted] appeared to be held to a higher level of scrutiny and criticism, and given lower levels of responsibility as compared to his residency running mate. His fellow resident was given more responsibility and more surgical operative procedures than [redacted] [redacted]as also submitted the inpatient record (photocopies) of a case that he has claimed was instrumental in the decision to terminate his status as a resident. The case was marked by the early postoperative death of a patient after a pneumonectomy for which he was the primary surgeon. Photocopies of another inpatient record have also been submitted by [redacted] This case was also highlighted by the death of a patient after pneumonectomy for which another resident was the primary surgeon and was not the subject of disciplinary action[redacted] as submitted record reviews of both of these cases by another thoracic surgeon (solicited b[redacted] [redacted]o found no fault i[redacted] management of his patient and possibly some fault in the management of the other patient[redacted]s claimed that the action taken against him by [redacted]s markedly different than that taken against the

5058-98

resident in the second case therefore demonstrating discrimination. [redacted] also submitted an affidavit stating that he was not given equal time for studying for board exams and that he was not given the same leeway to take care of personal business as his fellow residents. In the same affidavit, he stated that he had more weekend call than his fellow residents and that he was criticized for tardiness even though his fellow residents were much more frequently late.

7. [redacted] claimed that the process leading to probation and eventually termination of his residency was seriously flawed. He has stated that he was not fully informed of the terms of his probation and that he was not given adequate time or opportunity to address the Graduate Training Committee and the Commanding Officer at the time of his termination from residency. He has also asserted that [redacted] may have altered the memorandum of 23 June 1971 that detailed the reasons for probation to the Graduate Training Committee. He has submitted a cassette tape recording of conversations with the secretary of the Graduate Training Committee during which the secretary stated that [redacted] had taken the 23 June 71 memo from the file. He has noted apparent inconsistencies in that same memo to suggest that parts of it were written at different times than on the memo's date. He has stated that the specific nature of the complaints against him submitted by others throughout the command including nurses and corpsmen were not relayed to him before or during the residency probation or termination proceedings. [redacted] also submitted an affidavit in which he states that he informed [redacted] an incident that he believed to be an instance of poor nursing care that he brought to the attention [redacted] who did not treat the complaint seriously in [redacted] opinion [redacted] stated that poor care by nurses and corpsmen was common and that his insistence on better performance by them was the reason for their complaints against him.

8. [redacted] claimed that [redacted] behavior toward him worsened in July 1971 due [redacted] comments and suggestions during the course of treatment of a patient under [redacted] care who died in the early postoperative period [redacted] submitted photocopies of that patient's record and a review of the case solicited by [redacted] the same surgeon who reviewed the other two cases. The reviewer found fault in several aspects of the case, some of which [redacted] stated he had commented on to [redacted] during the case in an effort to change [redacted] approach. According to [redacted] that time [redacted] sought to prevent him from becoming board-certified in thoracic surgery. He has submitted a letter sent by [redacted] to one of [redacted] previous supervisors which requests information on [redacted] performance while working under that supervisor. He has also submitted a letter written by another surgeon describing a conversation initiated by [redacted] regarding [redacted] That surgeon noted that [redacted] stated he did not want [redacted] to pass the board exam in thoracic surgery.

9. In summary, [redacted] claimed that [redacted] discriminated against him throughout his time as a thoracic surgery resident. He has submitted items and given examples in an attempt to substantiate this claim and has requested that, as a result of this alleged discrimination, the fitness report entries and files in question be annotated as having been the result of an unreasonably biased evaluator. However, there are

alternative explanations for many of the items described by [redacted] r example, the unequal case totals may have been the result of behavior on the part of [redacted] that made [redacted] and/or the other attending surgeons on the Thoracic Surgery Service reluctant to give him primary surgeon responsibility during the early stages of his residency. In his letter, [redacted] wrote tha[redacted] treated differently than his fellow resident, but he also wrote [redacted] rough edges when he initially assumed his duties as a Resident at U.S. Naval Hospital, San Diego. He needed to learn the art of dealing with patients and subordinates." This issue alone could result in an unequal case load betwe[redacted] his fellow resident and is consistent with statements written by [redacted] the documents available regardin[redacted] probation and eventual termination from the residency.

10. In the example of the pneumonectomy case that [redacted] ointed to as being the major cause of his termination from the residency, the surgeon who reviewed the case pointed to a positive fluid balance of over three liters from the initial postoperative period to the time of death as being the main problem that led to the patient's demise (due to fluid overload and pulmonary edema). However, by the reviewer's own admission, this estimation did not take into account the large amount of blood found in the chest at the time of re-exploration. The operative report included a statement indicating that the chest was filled with clots and blood. This amount could easily be translated to 3 liters of blood loss in the chest in the period after the first surgery and would indicate that there was no substantial fluid overload since the blood loss would be added to the output and negate the positive fluid balance. Vital signs in the period after the re-exploration for bleeding revealed a central venous pressure of four that would also argue against gross fluid overload. Review of the record also revealed substantial hypotension throughout the approximately five hour postoperative period after the initial procedure (pneumonectomy). The patient's extremities were cool as noted by the nurse taking care of her in the postoperative period. The patient may have been in shock during much of this time consistent with a three liter postoperative blood loss and may have developed a pulmonary capillary leak syndrome in the remaining lung with resulting hypoxia and death. Finall[redacted] cated hemorrhage to be the antecedent cause of the patient's postoperative pulmonary edema in a hospitalization summary document signed by him 3 November 1971. Whether or not there was any mismanagement of this patient, the attending surgeons on the Thoracic Surgery Service may have been concerned about any number of issues regardin[redacted] insight as to the basic issues of the case or the postoperative complications. None of this would be apparent in the record as there might have been intraoperative technical issues or discussions about approach to the perioperative or postoperative care of the patient that caused the attending surgeons to feel that [redacted] ught process or approach was not adequate for his level of training. Details of these items would not be included in the written record.

11. The other pneumonectomy case that was reviewed has few similarities to the case just discussed other than the type of resection performed. The reviewer stated that there were contraindications to doing the case, but review of the record does not substantiate that firm contraindications were evident prior to the definitive attempt at resection. Preoperative mediastinal node biopsies were negative and the carinal

biopsy showed a subepithelial focus of tumor in a vessel rather than infiltrative tumor in the wall of the bronchus at that level. At the time of surgery, the subcarinal tumor mass was felt to be extrinsic to the bronchus rather than invading it and an adequate gross margin was visualized after dissection of the area. Microscopic evaluation of the proximal margin of the pneumonectomy specimen bronchus revealed squamous metaplasia rather than tumor. The patient had a slow downhill course to death over several days after the procedure that was felt to be due to oxygen toxicity by autopsy evaluation. The substantially different nature of the details of this case in comparison to the previous case discussed preclude any judgement regarding different treatment of the residents involved in either case.

12. Some of the other examples given [redacted] have alternate explanations. Even [redacted] remove the 23 June 1971 probation memo from the graduate training file alteration of the memo itself cannot be automatically assumed. In addition, [redacted] impression that [redacted] efforts to terminate him from the residency increased after the case discussed in paragraph 8 is contradicted by the fact that the case occurred after [redacted] been placed on probation and that Dr. [redacted] later rescinded the probation.

13. In addition, even if discrimination [redacted] could be proved, the fitness reports in question were signed by the hospital's commanding officer at the ti[redacted] nd not by [redacted] erefor[redacted] uld also have to be shown to have been an unreasonably biased evaluator to approv[redacted] request. Also, the graduate training committee members who discussed and decided upon probation and termination would have to be shown to have unreasonable bias in [redacted]. Neither of these items has been addressed to any significant degree in [redacted]

14. In conclusion, my recommendation is tha[redacted] uest should not be approved based on the available evidence. The annotation he has requested should be reconsidered only after a complete and unbiased review of the case. This would require the work of an impartial panel with independent access to the records and people involved in [redacted] ng during that period.

Very [redacted]